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# Mandating Coverage for Maternity Length of Stays: Certain Problems with the Good Idea

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MANDATING COVERAGE FOR MATERNITY LENGTH OF STAYS: CERTAIN PROBLEMS WITH THE GOOD IDEA

I. INTRODUCTION ..... 271

II. STATE LEGISLATION REGULATING MATERNITY STAY  
COVERAGE ..... 274

    A. *Ohio's Maternity Length-of-Stay Law* ..... 281

    B. *Maternity Standards Implemented in Cleveland* ..... 283

III. NATIONAL LEGISLATION—THE FEDERAL ROLE IN  
HEALTH CARE ..... 291

IV. HOW THE REGULATIONS MAY AFFECT MATERNITY  
HEALTH CARE ..... 297

V. CONCLUSION ..... 301

I. INTRODUCTION

The Newborns' and Mothers' Health Protection Act of 1996 (Newborns' Act), enacted on September 20, 1996, intends to ensure appropriate maternity health care for insured mothers and their newborn infants by mandating increased insurance coverage.<sup>1</sup> Specifically, insurance groups, health maintenance organizations (HMOs), and private payors who offer maternity coverage must cover at least forty-eight or ninety-six hours of post-natal hospital care.<sup>2</sup> The Newborns' Act, along with several and similar state laws, percolated during the 1996 presidential election.<sup>3</sup> The state legislation, including Ohio's Maternity Length-of-Stay Law (Maternity Law), nearly mirror the federal law

<sup>1</sup>6 U.S.C. § 601, et al. (1996).

<sup>2</sup>*Id.* at §§ 603-605.

<sup>3</sup>Lawrence L. Knutson, *Clinton seeks longer childbirth stays*, ATLANTA J. & CONST., May 12, 1996, at A17.

"Saving the life and health of mothers and newborns is more important than saving a few dollars," Clinton said in his weekly radio address. "I urge members of Congress to move legislation forward as soon as possible that makes this protection for mothers and their children the law of the land.

"No insurance company should be free to make the final judgment about what is medically best for newborns and their mothers," he said. "That decision should be left up to doctors, nurses and mothers themselves."

Politically, Clinton's appeal appeared to be matched to some potentially popular, low-cost "family value" issues he has raised in recent months. . . .

*Id.*

of which New Jersey law served as the blueprint.<sup>4</sup> The combined state and federal maternity laws intend to affect all payors which offer maternity health care coverage for mothers and newborns.

The battle ensued when insurers and HMOs (payors) imposed policy restrictions to achieve cost effective, quality maternity health care.<sup>5</sup> Medical groups, disagreeing with the policy restrictions, faced professional and financial incentives to either accept the policy or seek a new payor.<sup>6</sup> Likewise,

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<sup>4</sup>1995 N.J. Laws 117 (Memorials to the U.S. Government); 1994 N.J. Laws 2224; 1995 Md. Laws 888; 1996 Ohio Laws 199; *see also New Jersey Law Requires Minimal 48-Hour Stay for Women, Babies Following Childbirth*, BNA HEALTH CARE DAILY, July 3, 1995 [hereinafter *N.J. Law Requires Minimal 48-Hour Stay*].

<sup>5</sup>*See N.J. Law Requires Minimal 48-Hour Stay*, *supra* note 4.

"Our position has been that under the right circumstances, 24-hour discharge is safe," [Paul] Wolcott [spokesman for the New Jersey HMO Association] said, noting that most HMOs follow medical guidelines set by organizations such as the American College of Obstetrics and Gynecology for when 24-hour discharge is appropriate. "If you look at the peer-reviewed medical studies that have been done, they don't detect any difference in readmissions between those that are discharged after 24 hours and those with a traditional length of stay," Wolcott said.

He acknowledged the economic incentive to shorten hospital stays, which cost an average of \$1,800 a day in New Jersey, but added that HMOs have no incentive to set policies that result in short-term savings if they cause problems down the road.

*Id.*; *see also*, Newborns' and Mothers' Health Protection Act of 1995: *Hearings on § 969 Before the Senate Comm. on Labor and Human Resources* 104th Cong., 1st Sess. 80-81 (1995) [hereinafter *Hearings on § 969*] (Statement by Judith E. Frank, M.D. of Dartmouth Medical School).

The current impetus for even earlier discharge is not consumer driven but based on financial motivations of managed care organizations and third party payors. Hospitalization of mothers for delivery is the most frequent reason for hospitalizations in the United States and therefore is a logical target for cost limiting interventions.

*Id.*

<sup>6</sup>*President Signs Bill to Extend Maternity, Mental Health Coverage*, BNA HEALTH CARE DAILY, Sept. 27, 1996 [hereinafter *PRESIDENT SIGNS BILL*]; *Physicians Blame Insurance Profits for Trend in Early Hospital Releases*, BNA HEALTH CARE DAILY, Sept. 13, 1995 [hereinafter *Physicians Blame Insurance*].

Certain national medical groups alleged that payors directed doctors to release mothers and newborns from the hospital upon her insurance expiration regardless for the medical staff's best judgment. *Hearings on § 969*, *supra* note 5, at 52 (statement by Michael T. Mennuti, M.D. of the American College of Obstetricians and Gynecologists); *see also Id.* at 55 (statement by Palma E. Formica, M.D. of the American Medical Association). The AMA alleged that payor would "retaliate against physicians who keep patients in the hospital beyond the 24 hour threshold by reducing physician compensation or by dropping [the doctors] . . . from participating in the plan . . . , a practice known as deselection." *Id.* at 57. Some payors may have offered monetary incentives to mothers and coerced doctors who instigated release prior to the minimum time coverage. *Id.* at 58.

[W]e would prefer the bill to specifically prohibit the provision of monetary incentives to new mothers who leave the hospital before the minimum time

consumers faced financial burdens for violating the policy.<sup>7</sup> Thus, most physicians and consumers grudgingly accepted the payor policy. Payors felt that they effectively and appropriately contained costs.<sup>8</sup> However, certain medical and consumer groups considered the payor policies as harmful to both mother and newborn.<sup>9</sup>

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frames. We have learned that managed care companies sometimes reward mothers who leave early with written checks for money. In other cases, mothers are told their cost-sharing responsibility will be reduced the earlier they leave the hospital. With written clarification in the bill to prohibit these coercive practices, low income mothers will not be enticed into leaving before it is safe.

*Id.*

Doctor Palma E. Formica stated that "[t]he AMA has long opposed congressional intervention into a physician's clinical decision-making." *Hearings on § 969, supra* note 5, at 55, 57. However, "[t]he AMA firmly believes federal legislation is necessary to ensure that newborns and their mothers are protected from those who make medical decisions based on the bottom-line, rather than based on what is quality health care." *Id.*; but see *id.* at 62, 68-69 (statement by Sharon Levine, M.D. of Kaiser Permanente).

Over the past 50 years, we have witnessed tremendous changes in the practice of medicine, based on the orderly evolution of medical knowledge proceeding from scientific research to clinical application. . . . Legally stipulating the content of care [could] . . . disrupt[] . . . successful models of evidence-based medical practice innovation. Medical care is an evolving body of practice incorporating the science and art of medicine. Focusing on length of hospital stays for infants and their mothers is too narrow. The focus must be on assuring that mothers and children have access to appropriate care throughout the pregnancy and after delivery.

*Id.*

<sup>7</sup>Hospital care averages "\$1,500.00 per day." Michael A. Farinella, *Managed Care Shakeout: Competitors Vie for Bigger Slice*, 96 BEST'S REV. LIFE-HEALTH INS. ED. 34 (1995).

<sup>8</sup>*Id.*

Because hospital costs are so high, . . . , reducing the number of days in the hospital can lower an insurer's medical bill considerably, and usually with no loss in the quality of care to the patient. Many of the unnecessary hospital days come from the doctor's reluctance to send patients home promptly, usually as a precautionary measure. If there is no underlying medical reason to prolong a hospital stay, this becomes very costly to insurers and consumers, who ultimately pay . . . .

A catch-22 situation arises from the managed care perspective, where the incentive is for physicians to provide fewer medical services. This conflict probably will affect the quality of patient care, as well as patient-doctor relationships.

*Id.*

<sup>9</sup>A Dartmouth Hitchcock Medical Center study concluded that while "the potential consequences associated with the[] shorter hospital stays are largely unknown" newborns discharged before forty-eight hours have an increased risk of readmission. *Hearings on § 969, supra* note 88, at 80 (Judith E. Frank, M.D.). However, the standard "reduces health care delivery charges and makes economic sense for managed care and other third party payors." *Id.* In fact, the early discharge standard, including the

Medical groups petitioned first the state then the federal governments for legislative protection and intervention. The combined state and federal law intends to promote appropriate maternity health care. Unfortunately, the law fails to protect uninsured mothers and newborns. Also, the law indirectly standardizes maternity health care which may burden the evolution of maternity health care.

Federalism poses an interesting question for the Newborns' Act. Does America want its federal government to regulate maternity health care? Health care remains a local issue retained by the existing states at the United States (U.S.) Constitution's ratification. Over the years, the federal government has chipped away at the states' exclusive control of health care by legislating in health-related areas under other constitutionally delegated powers such as the spending and commerce powers. Americans ought to consider the consequences of unbalanced federalism when the federal government legislates in traditional state powers.

For simplification, the current payor trends, such as hospitals owning insurance companies and vice versa, will be condensed and generalized with insurance providers, HMOs, and other maternity payors as "payors." Likewise, not every medical group (certainly not the HMOs) advocated for state and federal legislation restricting payors in maternity health care. For simplification, any general mention of the medical profession or medical groups indicates those medical associations that advocated for the Newborns' Act.

This paper will outline the issues influenced by the Newborns' Act and the Maternity Law, including federalism. Likewise, the paper examines certain shortcomings of the maternity legislation. Section II focuses on Ohio's Maternity Law and whether it will prove effective as exemplified by Cleveland's maternity health care standards. Section III addresses the Newborns' Act and how it will influence federalism. Additionally, section III compares the Newborns' Act to the Maternity Law. Section IV explores how the concurrent regulations may affect maternity health care.

## II. STATE LEGISLATION REGULATING MATERNITY STAY COVERAGE

Physicians, hospitals, and health care providers continuously struggle to provide the very best medical care to mothers and their newborns despite the rising costs of maternity health care.<sup>10</sup> The U.S. has witnessed drastic changes in maternity health care services over the years, from home births, to hospital

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readmittance costs, saved the health care industry about \$7.2 million. *Id.* Dr. Frank warned that discharge "should not be an arbitrary policy mandated by third party payors. *Id.* However, Dr. Frank failed to acknowledge the arbitrary nature of the federal and state maternity laws. A better argument would consist of advocating no arbitrary policies from third party payors, hospitals, doctors, patients, or the state and federal government.

<sup>10</sup>Farinella, *supra* note 7, at 34.

wards, to high-tech home births, to private birthing rooms.<sup>11</sup> Medical groups and consumers continue in their quest for the ultimate maternity health care. In contrast, payors struggle to provide the most cost-effective coverage for the growing expenses that accompany a wellness event, birth.<sup>12</sup> Not often have the federal and state governments intervened between the competing interests of the two groups. Medical groups ought to provide the ultimate health care for mothers and newborns. However, payors can only provide so much of the enormous cost for maternity health care services.

Three important trends have driven maternity health care for the past fifty years.<sup>13</sup> Medical groups created the first trend after World War II when families respected and preferred the sterile hospital environment as the primary place for birthing.<sup>14</sup> "By the 1930's, the introduction of antiseptic techniques and surgical anesthesia had begun to reduce the death rate from complicated labor and delivery, providing a justification for hospital births."<sup>15</sup> Generally, mothers and newborns were separated to different rooms and physicians for at least five days post delivery.<sup>16</sup> However, Dr. Edith Jackson of Yale New Haven Hospital conducted research from 1946 to 1952 that changed the post war maternity standards.<sup>17</sup> Dr. Jackson observed and studied mothers and their newborns who stayed together post delivery and received medical care from the same provider. The research showed that mothers are an important source of care for the newborn and that the mother-newborn bond ought to be encouraged.<sup>18</sup>

Consumers created a second trend in the 1970's by demanding less medical intervention with uncomplicated births.<sup>19</sup> Thus, hospitals and physicians permitted shorter post-delivery care.<sup>20</sup> The consumer-driven trend stemmed from studies such as Dr. Jackson's which educated women on their importance in caretaking for their newborns. Maternity policy no longer separated mothers and newborns at birth for the duration of the hospital stay.<sup>21</sup> Likewise, breast feeding received acceptance and preference to formula feeding, while home

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<sup>11</sup>Hearings on § 969, *supra* note 5, at 62, 64 (Sharon Levine, M.D.).

<sup>12</sup>See generally, Farinella, *supra* note 7.

<sup>13</sup>Hearings on § 969, *supra* note 5, at 62, 64 (Sharon Levine, M.D.).

<sup>14</sup>*Id.*

<sup>15</sup>*Id.*

<sup>16</sup>*Id.*

<sup>17</sup>Hearings on § 969, *supra* note 5, at 62, 64 (Sharon Levine, M.D.).

<sup>18</sup>*Id.* "This research reestablished that the mother is an important source of care for the newborn infant and illustrated the safety and importance of early bonding between mothers and newborn infants." *Id.*

<sup>19</sup>*Id.*

<sup>20</sup>Hearings on § 969, *supra* note 5, at 62, 64 (Sharon Levine, M.D.).

<sup>21</sup>*Id.*

deliveries and nurse midwives gained respect equal to hospital deliveries and physicians.<sup>22</sup> "As a part of the [consumer-driven trend] . . . , physicians and hospitals came under increasing pressure from consumers to discharge mothers and infants from the hospital earlier [than the former five-day standard]."<sup>23</sup>

Third party payors instigated the debated trend which demanded that the physician release the mother and newborn just one day after an uncomplicated delivery.<sup>24</sup> Many payor policies covered one full hospital day upon the mother's entry.<sup>25</sup> Thus, if a woman entered the hospital at 5:00 p.m. and delivered by 8:00 p.m., her insurance coverage could terminate by 8:00 a.m. the following morning.<sup>26</sup> Bottom-line market theory and increasing medical costs drove payors to a cost-effective coverage.<sup>27</sup> While many mothers welcomed the trend, others reluctantly conceded only to find themselves with seriously ill infants.<sup>28</sup> Consumers and medical staff who dealt with the unexpectedly ill infants advocated for federal and state legislation regulating coverage for mothers and newborns.

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<sup>22</sup>*Id.*

<sup>23</sup>*Id.*

<sup>24</sup>*Hearings on § 969, supra* note 5, at 80, 80-81 (Judith E. Frank, M.D.).

<sup>25</sup>Farinella, *supra* note 7. "Insurers are in business to make money and any cost savings they can achieve adds to their bottom line. If patients are receiving unnecessary treatment or remain hospitalized longer than required, this results in significant waste with no additional medical benefits to the consumer." *Id.*

<sup>26</sup>*Hearings on § 969, supra* note 5, at 51 (statement by Senator Bill Bradley, D-N.J.).

<sup>27</sup>*Id.* at 55 (Palma E. Formica, M.D.).

The AMA agrees that there is room for physicians to become more efficient, and we are currently pursuing avenues to stream-line our practices and procedures. However, we cannot practice good medicine and deliver quality health care to our patients if our medical decisions are constantly being second-guessed by insurance company employees who often lack any medical training or experience. In many cases, managed care guidelines or protocols are gradually replacing physician judgment. In addition, managed care companies often erect bureaucratic hurdles to obstruct appeals.

*Id.*

<sup>28</sup>*Id.* at 81-82. (statement by Augusto Sola, M.D. of University of California San Francisco Medical Center).

One study in a particular state showed that with "early discharge" of newborn infants considered healthy, the risk of readmissions and of visits to the emergency room are 50 to 70 percent higher, respectively. These two issues can have long lasting psychological effects on the infants and their families due to what is known as the "vulnerable child syndrome."

Several infants with serious reversible and irreversible illness have been recently reported in association to these unevaluated changes in clinical practice.

*Hearings on § 969, supra* note 5, at 81-82 (Augusto Sola, M.D.).

Advocates for the maternity laws emphasized the dramatic and frighteningly possible dangers to newborns released according to the prior payor policy. Karen Davies testified that she and her daughter were released from their Kansas City hospital against the hospital doctors' and nursing staff's better judgment because Davies' coverage expired at twenty-four hours.<sup>29</sup> Davies and her daughter received one medical in-home visit by a nurse.<sup>30</sup> Although the first (payor-covered) nurse noticed the newborn's jaundice, not until a second, presumably uninsured visit did Davies realize her daughter's dangerous medical condition.<sup>31</sup> Fortunately, Davies' daughter, although very ill, survived without any subsequent harm.<sup>32</sup> Regardless of the visiting nurse and hospital staff, Davies argues that her payor acted inflexible and ultimately directed her doctor's medical judgment.<sup>33</sup> Thus, Davies blames her payor and its contract for her daughter's illness. Perhaps had Davies stayed an extra day in the hospital, the medical staff would have identified and treated her daughter's illness promptly. Thus, because the Davies went home according to policy restriction, Davies' daughter suffered an illness.

Advocates of the legislation also focused on sympathy for new mothers unqualified to identify illness in the infant or troubleshoot when first breast feeding.<sup>34</sup> Consider N.J.'s Senator Bradley's statement to the U.S. Senate.

[T]hink about what . . . "drive-through deliveries" [twenty-four hour coverage post delivery standard] mean[s] to millions of American mothers. Imagine a typical first-time mother, who has just undergone a long and difficult labor. Twenty-four hours after giving birth, she is both physically and mentally exhausted. She has been too tired to learn what symptoms, both in her baby and herself, are the warning signs of potentially dangerous illnesses. There may be few supports at home to help her cope with the overwhelming responsibilities of caring for herself and her baby in the first few days after birth. Nevertheless, she is sent home, left to muddle through as best she can. All she can do is

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<sup>29</sup>*Id.* at 77 (statement by Karen L. Davies of Lawrence, Kansas).

<sup>30</sup>*Id.*

<sup>31</sup>*Id.* at 77-78.

<sup>32</sup>*Hearings on § 969, supra* note 5, at 79 (Karen L. Davies).

<sup>33</sup>*Id.*

<sup>34</sup>*Id.* at 3-5 (statement by Senator Kassenbaum, R-Kan.).

In addition, providers believe that a 24-hour stay is often too short for new mothers to be taught basic infant care skills, such as breast-feeding. Many mothers are not physically capable of providing for a newborn's needs 24 hours after giving birth, and many do not have an adequate support system at home to feed and care for their new child.

*Id.*



hope no problems occur, fearing that if they do, there is little chance for recognition and treatment.<sup>35</sup>

While compassionate, Senator Bradley's focus on the "typical first-time mother['s]" experience fails to identify the maternity issues affecting all women. First of all, childbirth is difficult on all women whether first, second, or ninth time mothers. Secondly, each birth differs. A "typical first-time mother" may have an easier birth compared to a woman delivering her third child. The argument fails as illogical because women can learn symptoms of illness for themselves and their newborns, and will do so, with or without government intervention. Protective regulations on payors ought not focus on first-time mothers nor on the mother-infant relationship. After all, forty-eight hours of hospital care will not significantly help a first-time or an experienced mother who lacks "supports at home to help her cope with the overwhelming responsibilities of caring for herself and her baby in the first few days after birth."<sup>36</sup> Nor will twenty-four additional hours of hospital care help her to "muddle through as best she can."<sup>37</sup> Finally, additional hospital care does not guarantee that the hospital will teach, nor that the mother will learn, all she needs to know upon returning home with her newborn. Dr. Jackson's research, as presented by Dr. Sharon Levine of Kaiser Permanente, "reestablished that the mother is an important source of care for the newborn infant and illustrated the safety and importance of early bonding between mothers and newborn infants."<sup>38</sup> Dr. Jackson's research helped the maternity health care's evolution. By the 1970's, many women accepted nurse midwives and home births in attempts to de-medicalize child birth.<sup>39</sup>

At the heart of the payor policy conflict lied statistics, i.e. statistics that militate against twenty-four hour hospital stays.<sup>40</sup> Medical groups argued that payor-based policy capitalized on arbitrary medical records and internal formulations.<sup>41</sup> Risk-benefit reports supported payors in their deduction that women and newborns needed very little hospital care.<sup>42</sup> However, individual reports of infant illness or death which may have been prevented with increased hospital care strongly rebut the Risk-benefit reports. Arguably, the latest payor trend took the consumer trend to extremes.

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<sup>35</sup>Hearings on § 969, *supra* note 5, at 51 (Senator Bill Bradley).

<sup>36</sup>*Id.*

<sup>37</sup>*Id.*

<sup>38</sup>*Id.* at 64 (Sharon Levine, M. D.).

<sup>39</sup>Hearings on § 969, *supra* note 5, at 64 (Sharon Levine, M.D.).

<sup>40</sup>See generally N.J. Law Requires Minimal 48-Hour Stay, *supra* note 4; see also *Physicians Blame Insurance*, *supra* note 6.

<sup>41</sup>*Physicians Blame Insurance*, *supra* note 6.

<sup>42</sup>*Id.*; see also Jady DeGiralomo, *Legislation Undermines Us All*, 16 (1) J. HEALTH CARE MARKETING 28 (1996).

Although the legislative intent focused on the maternity health care, obviously the medical and payor groups engaged in an unspoken economic battle. After all, the legislation directs payors to cover a greater amount of maternity health care costs. Uninsured women and newborns are not presently guaranteed coverage of forty-eight or ninety-six hours of hospital care. Consider Paul Feldstein's paradigm which asserts that every negotiating member influencing legislation gains or abandons a self-serving desire.<sup>43</sup> For example, political popularity may drive politicians, bottom-line costs may motivate payors, and bottom-line reimbursement may move hospitals and physicians to influence legislation.<sup>44</sup> Medical associations seeking better health care standards can independently create such standards within the hospital regardless of legislation and costs. For example, hospitals can offer prenatal education or absorb the cost of in-home follow-up care. Yet, U.S. health care costs are too excessive for private and successful hospitals to absorb uninsured expenses.<sup>45</sup> Likewise, many hospitals already promote pre- and post-natal education. However, such education may be unappreciated by clients or ineffective for patients needing serious medical attention. Medical groups chose to lobby politicians to regulate private contracts between payors, physicians, and hospitals. According to Feldstein, "[L]egislation redistributes wealth."<sup>46</sup> Likewise, under Feldstein's self-interest paradigm, perhaps medical groups, frustrated and angry with payor profits, realized that physicians produce the work product and carry the responsibility of health care. Perhaps medical groups realized that in participating with successful and self-serving payors, physicians became disenfranchised in the medical profession. Why do physicians submit to payor contracts knowing that a payor may ultimately manipulate physician autonomy?

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<sup>43</sup>PAUL J. FELDSTEIN, *THE POLITICS OF HEALTH LEGISLATION*, 3 (1988).

<sup>44</sup>*Id.*

The approach used . . . to explain legislative outcomes - the Self-Interest Paradigm - assumes that individuals act according to self-interest, not necessarily the public interest. Individuals, as legislators or voters, are assumed to act no differently when it comes to politics than they act in private economic markets; they pursue their self-interest. For example, legislators (and regulators) are assumed to act so as to maximize the political support they receive. Legislators require political support to be reelected. Organized groups that are able to provide greater political support are expected to have greater political influence than other groups or than voters who are not organized. Organized groups seek to achieve through legislation what they cannot achieve through the marketplace. Such legislative benefits provide producers with greater incomes and organized, politically powerful population groups with economic gains such as net subsidies.

*Id.*

<sup>45</sup>See generally Farinella, *supra* note 7.

<sup>46</sup>FELDSTEIN, *supra* note 43, at 3.

Coincidentally serving to undermine [physician] autonomy is the sheer growth of the profession - from 142 professionally-active physicians per 100,000 population in 1950 to 180 in 1975 and 228 in 1985, with 260 projected for the year 2000. Likewise, the number of group practices, where physician-managers help to socialize their colleagues into acceptance of clinical limitations, has grown from 6,371 in 1969 to 10,762 in 1980 to 17,556 in 1986. Of the non-federal physicians in practice today, nearly one-fourth are salaried. As the average debt of medical school graduates (measured in constant dollars) climbed from \$19,700 in 1981 to \$28,000 in 1986 [to \$63,000 in mid-1990's], most graduates found few options other than salaried slots. More and more dependent upon the purpose and character of the employing organizations, physicians face such trends contributing to their "deprofessionalization", or a "proletarianization" of physicians.<sup>47</sup>

Perhaps payors have wrongfully benefited from changes within the physician profession. If payors wrongfully usurped physician autonomy, then medical groups ought to lobby for legislation affecting their independence. However, in light of Feldstein's paradigm, soliciting legislation under the pretext of maternity health care to redistribute profits to medical groups exemplifies a system unsympathetic to those women and newborns not directing funds to the participants.<sup>48</sup>

The federal and state legislation severs the payor's strong hold over physicians and hospitals. However, payors will not likely conform to the new mandates passively. Prior to the Newborns' Act, the State of New Jersey witnessed one backlash whereas payors manipulated hospital contracts to offset the financial effect of forty-eight hour maternity coverage.<sup>49</sup> Certain New Jersey payors negotiated a per-case maternity coverage rather than a per-diem coverage which presumably shifts financial loss to the hospital.<sup>50</sup>

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47J. Warren Salmon, et al., *The Futures of Physicians: Agency and Autonomy Reconsidered*, 11 THEORETICAL MED. 261, 270 (1990); see also John Gray, *Managed Care 1996: A Continuing Revolution*, 43 (9) RISK MGMT. 14 (1996); NIH *Reauthorization: Hearings Before the Comm. on Labor and Human Resources*, 1996 WL 10163334, \*3 (May 7, 1996) (statement of Veronica Catanese, M.D., President, American Federation for Clinical Research).

48Feldstein, *supra* note 43, at 3; see also Birt Harvey, *Toward a national child health policy*, 264 JAMA 252 (1990) ("14 million women of childbearing age have no maternity care coverage"); see also Interview with Mark Chassim, Director of New York Health Care, in New York (1994) (on file with Dr. Samuel Gorovitz, Syracuse, N.Y.) (40 million Americans have no health insurance).

491994 N.J. A.R. 180 206th Legis. 2d Annual Sess. (1995).

50*Id.* Under a per-case coverage, the payor likely determines a median cost of an average low to medium risk birth and applies that cost to every client. The hospital in turn risks future costs if the patient has a complicated birth or recovery. Several New Jersey politicians oppose per-case coverage and urge state regulators to investigate per-case contracts. *Id.*

Regardless, on July 18, 1996, Governor George Voinovich signed the Ohio Maternity Length-of-Stay Law.<sup>51</sup> Ohio joined several other states passing legislation mandating that payors provide forty-eight or ninety-six hours of post-natal hospital care for insured mothers and newborns.<sup>52</sup> The State of Ohio also mandates that the public payor conform to the hospital and follow-up coverage standard.<sup>53</sup>

#### *A. Ohio's Maternity Length-of-Stay Law*

The Ohio Maternity Law states:

(A) [E]ach individual or group health maintenance organization contract . . . that provides maternity benefits shall provide coverage of inpatient care and follow-up care for a mother and her newborn as follows:

(1 ) [A] minimum of forty-eight hours of inpatient hospital care following a normal vaginal delivery and a minimum of ninety-six hours of inpatient hospital care following a caesarean delivery. Services covered as inpatient care shall include medical, educational, and any other services that are consistent with the inpatient care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.

(2) [A] physician-directed source of follow-up care. Services covered as follow-up care shall include physical assessment of the mother and newborn, parent education, assistance and training in breast or bottle feeding, assessment of the home support system, performance of any medically necessary and appropriate clinical tests, and any other services that are consistent with the follow-up care recommended in the protocols and guidelines developed by national organizations that represent pediatric, obstetric, and nursing professionals.<sup>54</sup>

Ohio's Maternity Law carefully identifies "contract" as the focus of the restrictions. Thus, the "contract shall cover" a hospital stay for either forty-eight hours for a normal birth or ninety-six hours for a caesarean birth.<sup>55</sup> The payor "contracts shall [also] cover a physician-directed source of follow-up care."<sup>56</sup>

The payor contracts include "each individual or group [HMO] . . . contract delivered, issued for delivery, or renewed in [Ohio] . . . that provides maternity

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<sup>51</sup>1996 Ohio Laws 199.

<sup>52</sup>*Id.*; 1994 N.J. Laws 2224; 1995 Md. Laws 888.

<sup>53</sup>1996 Ohio Laws 199 § 5111.018(A)(1)(2).

<sup>54</sup>*Id.* at § 1742.45(A)(1)(2).

<sup>55</sup>*Id.* at § 1742.45(A)(1).

<sup>56</sup>*Id.* at § 1742.45(A)(2).

benefits . . . ,<sup>57</sup> policy of sickness and accident insurance delivered, issued for delivery, or renewed in [Ohio] . . . that provides maternity benefits . . . ,<sup>58</sup> public employee benefit plan established or modified in [Ohio] . . . that provides maternity benefits . . . ,<sup>59</sup> [and the state] medical assistance program."<sup>60</sup>

The postpartum hospital care encompasses parent education, training, outreach, home assessment, and other interventions consistent with national maternity health care professional groups.<sup>61</sup> The service coverage will allow nurses and doctors to facilitate new mothers and women who do not partake in prenatal education. National maternity professional organizations, once disenfranchised by payor policies, now control the permissible scope of covered inpatient services. However, the law does not mandate that a mother give birth or stay in the hospital for forty-eight or ninety-six hours.<sup>62</sup>

Follow-up care consists of medical assessment, outreach, parent education, and any other intervention the physician deems appropriate.<sup>63</sup> Follow-up care coverage changes according to inpatient care. Under the Maternity Law, a mother who leaves the hospital prior to forty-eight hours receives coverage of follow-up care occurring within forty-eight hours of discharge.<sup>64</sup> However, mothers that stay in the hospital for the full forty-eight hours receive medically necessary follow-up care.<sup>65</sup> The law does not "require a contract to cover inpatient or follow-up care that is not received in accordance with the contract's terms pertaining to the health care professionals and facilities from which an individual is authorized to receive health care services."<sup>66</sup> Like the inpatient services, the law does not mandate a mother to accept the follow-up care.<sup>67</sup>

Under the Ohio Maternity Law, the public health council must test newborns for phenylketonuria (PKU), homocystinuria, galactosemia, and hypothyroidism.<sup>68</sup> However, the public health council shall not test a newborn in violation of the parents' religious beliefs.<sup>69</sup> Ohio legislators have created an opportunity for health care professionals to test newborns for identifiable and

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<sup>57</sup>1996 Ohio Laws 199 § 1742.45(A).

<sup>58</sup>*Id.* at § 3923.63(A).

<sup>59</sup>*Id.* at § 3923.64(A).

<sup>60</sup>*Id.* at § 5111.018(A).

<sup>61</sup>1996 Ohio Laws 199 § 1742.45(A)(1).

<sup>62</sup>*Id.* at § 1742.45 (B)(2)(3).

<sup>63</sup>*Id.* at § 1742.45(A)(2).

<sup>64</sup>*Id.* at 1742.45(A).

<sup>65</sup>1996 Ohio Laws 199 § 1742.45(A)(1).

<sup>66</sup>*Id.* at § 1742.45(D)(1).

<sup>67</sup>*Id.* at § 1742.45(D)(2).

<sup>68</sup>*Id.* at § 3701.501(A).

<sup>69</sup>1996 Ohio Laws 199 § 3701.501(B).

treatable illness. As long as maternity health care professionals standardize the testing during covered follow-up care, the newborn must be tested.

Likewise, Ohio legislators severed payor strong hold over Ohio physicians. The Maternity Law prohibits payors from financially enticing the mother or physician from seeking an appropriate hospital and follow-up care.<sup>70</sup> Also, payors may not cancel physician or hospital contracts for determining and directing patient treatment outlined within the Maternity Law in violation of payor wishes.<sup>71</sup>

Generally, the state assistant programs providing maternity coverage must conform to the same restrictions as private payors. However, under the Maternity Law, private payors who violate the incentive prohibitions partake in an unfair and deceptive insurance act or practice.<sup>72</sup> The Maternity Law does not specify the violation when performed by a state agent. Thus' private payors suffer a greater burden for violating a law which binds private and public payors.

The current Maternity Law differs from the proposed bill sent to the Ohio legislature. In addition to the hospital hours, the prior bill mandated three medical home visits within 100 hours of discharge upon the mother's request or the physician's order.<sup>73</sup> Now, if the doctor and mother determine upon a hospital stay of less than the legislative time, then the payor must cover follow-up care which occurs within forty-eight hours of discharge.<sup>74</sup> Likewise, when the physician determines follow-up care as medically necessary, payors must cover the care.<sup>75</sup> Remember that payors may not contractually punish or financially entice physicians to order less than appropriate care for the mother and newborn. Thus, under the Maternity Law, physicians have recaptured the control over the maternity ward. However, physicians and hospitals struggle to understand and determine the nuances of the recent legislation. Thus, time will tell if the Maternity Law truly protects physicians' authority.

### *B. Maternity Standards Implemented in Cleveland*

A sampling of the Cleveland maternity health care services shows that hospitals generally support legislation that benefits mothers and newborns.<sup>76</sup>

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<sup>70</sup>*Id.* at § 1742.45(C)(1)(a)-(b).

<sup>71</sup>*Id.*

<sup>72</sup>*Id.* at § 1742.45(C)(2).

<sup>73</sup>S.J. Res. 199, 121st Ohio Gen. Assembly, 1995-1996 Reg. Sess., 1995 Ohio S.B. 199.

<sup>74</sup>1996 Ohio Laws 199 § 1742.45(A)(2).

<sup>75</sup>*Id.*

<sup>76</sup>Telephone Interview with Sharon Carpinello, Assistant Unit Manager of Labor and Delivery, The Cleveland Clinic Foundation (Dec. 28, 1995) [hereinafter Clinic I]; Telephone Interview with Barbara Wilford, O.B. Manager of Labor and Delivery, Meridia-Hillcrest Hospital (Jan. 1, 1996) [hereinafter Hillcrest I]; Telephone Interview with Denise Kosty, Unit Manager of Labor and Delivery, MetroHealth Hospital (Dec. 28, 1995) [hereinafter MetroHealth I]; Telephone Interview with Karen Westmyer,

The Cleveland Clinic (Clinic), Meridia-Hillcrest (Hillcrest), and MetroHealth, Cleveland hospitals offering maternity services, participated in telephone interviews before and after the legislation enacted at the federal and state levels.<sup>77</sup> The author talked at length with representatives of each hospitals' maternity or women's unit. The three hospitals claimed to have successfully operated under the twenty-four hour standard.<sup>78</sup>

Each hospital representative answered a series of questions concerning the hospital and the federal or state legislation. The first interview, conducted in January of 1996, consisted of hospital information such as hospital births per year and percentages of payees as self-paid, state covered, or commercially insured. MetroHealth, a county hospital, services the greatest number of births at approximately 4,000 per year.<sup>79</sup> Hillcrest services approximately 3,500 births per year.<sup>80</sup> The Clinic opened its maternity unit in May, 1995, and at the first interview averaged about eighty to 100 births per month.<sup>81</sup> The Clinic representative predicted a dramatic rise in births as a result of additional payor contracts.<sup>82</sup> By the second interview in January 1997, the Clinic serviced approximately 150 births per month or 1,800 per year.<sup>83</sup> MetroHealth manages the greatest number of publicly assisted births which average about sixty percent and the greatest number of self-paid women at approximately fifteen percent.<sup>84</sup> Both Hillcrest and the Clinic have minimal self-paid mothers, and of the two, Hillcrest deals with a very small percentage of publicly assisted patients.<sup>85</sup>

At the first interview, the three hospital representatives voiced dislike for the payor twenty-four hour policy. However, at the first interview each representative expressly denied the allegation that payors dictated health care within their hospitals.<sup>86</sup> Each Cleveland hospital claimed to have retained the mother and newborn an extra day or more if either mother or infant needed

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Director of Women's Services, The Cleveland Clinic Foundation, (Jan. 6, 1997) [hereinafter Clinic II]; Telephone Interview with Casey Toohig, Perinatal Coordinator for the Mother and Baby Unit, Meridia-Hillcrest Hospital (Dec. 30, 1996) [hereinafter Hillcrest II]; Telephone Interview with Denise Kosty, Unit Manager of Labor and Delivery, MetroHealth Hospital (Jan. 7, 1997) [hereinafter MetroHealth II].

<sup>77</sup> See interviews cited *supra* note 76.

<sup>78</sup> Clinic I, *supra* note 76; Hillcrest I, *supra* note 76; MetroHealth I, *supra* note 76.

<sup>79</sup> MetroHealth I, *supra* note 76.

<sup>80</sup> Hillcrest I, *supra* note 76.

<sup>81</sup> Clinic I, *supra* note 76.

<sup>82</sup> *Id.*

<sup>83</sup> Clinic II, *supra* note 76.

<sup>84</sup> MetroHealth I, *supra* note 76.

<sup>85</sup> Hillcrest I, *supra* note 76; see also Clinic I, *supra* note 76.

<sup>86</sup> In fact, all three hospitals exercised internal methods for boarding a mother and newborn if the need existed. Clinic I, *supra* note 76; Hillcrest I, *supra* note 76; MetroHealth

the additional time.<sup>87</sup> The hospitals used a variety of factors to determine the need for additional post-delivery hospital care. The hospitals' considered the mother's social and emotional support at home, the amount of bleeding at birth, lab results, and vital signs of both mother and newborn.<sup>88</sup> MetroHealth also checked for the newborn's transition and physical appearance, but not the mother's experience with childbirth because generally, few women are prepared for mothering responsibilities at twenty-four hours post birth regardless of her experience.<sup>89</sup>

Prior to the legislation, all three Cleveland hospitals asserted that home visitation ensured the optimal health care for mothers and newborns.<sup>90</sup> Hillcrest provided the in-home visitation in addition to one phone call between the time of the home visit and the first pediatrician appointment at no charge to the mother.<sup>91</sup> Hillcrest sought reimbursement from the payor and absorbed any uncovered services.<sup>92</sup>

In fact, Hillcrest, committed to optimum women's health care services, believed that the extended hospital stay assists the mother past the "taking-in stage"<sup>93</sup> of birthing when she may better perform the necessary care-taking functions.<sup>94</sup> Also, Hillcrest incorporates post-natal courses into its prenatal educational programs for expecting parents.<sup>95</sup> While not all of Hillcrest maternity patients participate in the prenatal programs, those that do receive reviews of the post-natal education component after birth and prior to leaving the hospital.<sup>96</sup> Hillcrest, unlike other hospitals, can and does afford innovative programs for its maternity unit.<sup>97</sup> Hospitals such as MetroHealth, considerably more strapped for funding, may incorporate similar programs in their prenatal education classes for cost effectiveness.

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I, *supra* note 76.

<sup>87</sup>Clinic I, *supra* note 76; Hillcrest I, *supra* note 76; MetroHealth I, *supra* note 76.

<sup>88</sup>Clinic I, *supra* note 76; Hillcrest I, *supra* note 76; MetroHealth I, *supra* note 76.

<sup>89</sup>MetroHealth I, *supra* note 76.

<sup>90</sup>Clinic I, *supra* note 76; Hillcrest I, *supra* note 76; MetroHealth I, *supra* note 76.

<sup>91</sup>Hillcrest I, *supra* note 76.

<sup>92</sup>Hillcrest II, *supra* note 76.

<sup>93</sup>Hillcrest I, *supra* note 76. Ms. Wilford believes that mothers should stay up to forty-eight hours because according to Robin, the mother is still in the "taking-in stage" of birth at twenty-four hours. The mothers are better able to handle the necessary care-taking functions at forty-eight hours instead of twenty-four hours. *Id.*; see also ROBIN LIM, AFTER THE BABY'S BIRTH . . . A WOMAN'S WAY TO WELLNESS 8-13 (1991).

<sup>94</sup>Hillcrest I, *supra* note 76.

<sup>95</sup>*Id.*

<sup>96</sup>*Id.*

<sup>97</sup>*Id.*



MetroHealth faces cost-effective issues on a daily basis because it services Cleveland's lowest socioeconomic population.<sup>98</sup> In fact, MetroHealth asserted, "[t]he hospital can give the best medical care but if the woman doesn't have the support at home with follow-up, the care is inadequate. The mandate should be focused on the at-home care."<sup>99</sup> However, MetroHealth and the Clinic agreed that legislating forty-eight hours of hospital care in addition to three home visits, as Ohio attempted, would excessively burden maternity health care costs.<sup>100</sup>

By the second interview in January 1997, both the federal and state laws enacted and Ohio hospitals had been functioning under the Maternity Law for at least three months. The representatives felt that the Maternity law cured the problem of payor control.<sup>101</sup> Each representative voiced support of the Ohio legislation.<sup>102</sup> Hillcrest openly advocated for the Newborns' Act along with the Maternity Law.<sup>103</sup> The three representatives claimed that the Newborns' Act's impact in 1998 will not disrupt hospital standards.<sup>104</sup>

All three representatives asserted that consumers and selective physicians demand the forty-eight hour hospital stay. The Clinic, who completed a maternity ward expansion just prior to the Maternity Law's effective date, services a full capacity for longer periods compared to service before the law.<sup>105</sup> Likewise, Hillcrest services an increased capacity of mothers and newborns.<sup>106</sup> Hillcrest adjusted its maternity staff to a flexible system to conform with the longer hospital stays and the full capacity maternity ward.<sup>107</sup> The Hillcrest representative asserted that about eighty to ninety percent of patients remain

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<sup>98</sup>MetroHealth I, *supra* note 76.

<sup>99</sup>*Id.*

<sup>100</sup>*Id.*; *see also* Clinic I, *supra* note 76.

<sup>101</sup>However, the representatives did not mention that payors effectively controlled physicians in their respective hospitals. The representatives spoke of a general trend for payor control of the physician or the patient. Clinic II, *supra* note 76; Hillcrest II, *supra* note 76; MetroHealth II, *supra* note 76.

<sup>102</sup>Clinic II, *supra* note 76; Hillcrest II, *supra* note 76; MetroHealth II, *supra* note 76.

<sup>103</sup>Hillcrest I, *supra* note 76; Hillcrest II, *supra* note 76.

<sup>104</sup>Clinic II, *supra* note 76; Hillcrest II, *supra* note 76; MetroHealth II, *supra* note 76.

<sup>105</sup>Clinic II, *supra* note 76.

<sup>106</sup>Hillcrest II, *supra* note 76.

<sup>107</sup>*Id.*

in the hospital for forty-eight hours.<sup>108</sup> Finally, MetroHealth services about fifty percent of mothers and newborns for forty-eight hours.<sup>109</sup> MetroHealth's representative claims that consumers seem to want the additional hospital care more so than physicians.<sup>110</sup>

The recent legislation does contain a few glitches that physicians, consumers, hospital staffs, and payors attempt to resolve. First, follow-up care remains undefined by the legislation. Serious confusion exists as to what service shall be covered and which service shall be optional.<sup>111</sup> Also, "home visit" creates a technical concern because certain people may consider the visit as a component of follow-up care.

The Clinic representative asserted a distinction between home visits and follow-up care.<sup>112</sup> The Clinic functions under the assumption that payors must cover follow-up care which consists of visits to the doctor's office and testing in a clinical setting regardless of medical necessity.<sup>113</sup> In contrast, a home visit consists of a nurse traveling to a mother's home for intervention.<sup>114</sup> The Clinic believes that payors shall cover home visits if the mother remains in the hospital less than forty-eight hours or if the physicians determines the visit to be medically necessary.<sup>115</sup> Hillcrest differs from the Clinic in interpreting the distinction of home visit, follow-up care, and mandated coverage.<sup>116</sup>

In fact, of the three hospitals interviewed, Hillcrest may suffer the most adverse effects from the Maternity Law. Prior to the law, Hillcrest strove for a strong women's health care program.<sup>117</sup> When payors refused to cover costs for appropriate maternity health care, the hospital absorbed the costs and permitted the service.<sup>118</sup> For example, Hillcrest offered a home visit and a phone call prior to the first doctor's appointment to mothers regardless of the payor policy.<sup>119</sup> Hillcrest stopped offering the service once the Maternity Law enacted because mothers have the option of forty-eight hours or a home visit with less than forty-eight hours of hospital care.<sup>120</sup> Hillcrest assumes that the

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<sup>108</sup>*Id.*

<sup>109</sup>MetroHealth II, *supra* note 76.

<sup>110</sup>*Id.*

<sup>111</sup>Clinic II, *supra* note 76; Hillcrest II, *supra* note 76; MetroHealth II, *supra* note 76.

<sup>112</sup>Clinic II, *supra* note 76.

<sup>113</sup>*Id.*

<sup>114</sup>*Id.*

<sup>115</sup>*Id.*

<sup>116</sup>Hillcrest II, *supra* note 76.

<sup>117</sup>*Id.*; Hillcrest I, *supra* note 76.

<sup>118</sup>Hillcrest I, *supra* note 76; Hillcrest II, *supra* note 76.

<sup>119</sup>Hillcrest I, *supra* note 76.

<sup>120</sup>Hillcrest II, *supra* note 76.

Maternity Law mandates forty-eight hours of hospital care or twenty-four hours of hospital care and a home visit.<sup>121</sup> Thus, Hillcrest's superior postpartum care has been adjusted to conform to the Maternity Law. Hillcrest has created several package plans, which the consumer may purchase, to compensate for the home care system's elimination.<sup>122</sup>

Additionally, Hillcrest no longer assures its maternity patients a private room.<sup>123</sup> Now, patients must share rooms more often and for a greater amount of the hospital stay.<sup>124</sup> The Hillcrest representative asserted that a lack of private rooms may cause consumer dissatisfaction with the hospital.<sup>125</sup>

Likewise, Hillcrest's representative claimed that the public concern with payor policy has created a chilling effect from the payor.<sup>126</sup> Now, a mother with policy questions or concerns receives blanket statements such as, "your policy covers whatever your physician feels is medically necessary," from her payor.<sup>127</sup> Hillcrest's representative faulted the payor as inaccurate and ambiguous.<sup>128</sup> Under certain circumstances, the payor still may refuse certain "medically necessary" services.<sup>129</sup> Also, the term "medically necessary" remains undefined and unclear by the law. Hillcrest fears that payor inaccuracies and ambiguities may cause some of the medical costs to fall onto the patients.<sup>130</sup>

MetroHealth's representative also faulted the Maternity Law for failing to define follow-up care.<sup>131</sup> For cost effectiveness, MetroHealth refers all home visits to a nursing service.<sup>132</sup> Thus, MetroHealth automatically refers mothers who stay in the hospital less than forty-eight hours and mothers whose care demands a home visit.<sup>133</sup> However, MetroHealth does not track the home services corporation.<sup>134</sup> Once MetroHealth refers a mother to the home service corporation, the referral service checks with the payor to secure coverage prior

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<sup>121</sup> *Id.*

<sup>122</sup> *Id.*

<sup>123</sup> *Id.*

<sup>124</sup> Hillcrest II, *supra* note 76.

<sup>125</sup> *Id.*

<sup>126</sup> *Id.*

<sup>127</sup> *Id.*

<sup>128</sup> Hillcrest II, *supra* note 76.

<sup>129</sup> *Id.*

<sup>130</sup> *Id.*

<sup>131</sup> MetroHealth II, *supra* note 76.

<sup>132</sup> *Id.*

<sup>133</sup> *Id.*

<sup>134</sup> *Id.*

to a visit.<sup>135</sup> Possibly, some of the home visits, especially the medically necessary home visits, do not occur for lack of coverage.<sup>136</sup>

All three hospitals feel that maternity health care ought to focus on education. The Clinic representative views the Maternity Law as providing options, not mandating longer hospital stays.<sup>137</sup> Also, the Clinic feels that the family and community must learn of their options under the Maternity law.<sup>138</sup> Additionally, maternity health care legislation ought to focus on the wellness event, birth, and provide consumer option of appropriate health care instead of debating shorter and longer hospital stays.<sup>139</sup>

In addition to education, Hillcrest strives to develop maternity health care into a continuum of care.<sup>140</sup> Thus, the intervention (and payor coverage) ought to begin at the earliest prenatal stages and continue well past birth to post-natal support or parenting groups.<sup>141</sup> For example, hospitals may develop programs which permit expecting mothers to sign hospital forms prior to her labor as a way to ease the birthing process.<sup>142</sup> Also, a mother ought to have a home visit as a part of the follow-up care.<sup>143</sup>

Hillcrest also wishes for additional changes from the payors. For example, payor telephone hot lines available during nonbusiness hours and weekends may eliminate unwanted stress on mothers who currently cannot speak with payor representatives during non-business hours.<sup>144</sup> Many mothers, especially mothers entering the hospitals on weekends, cannot present questions or concerns to payors for lack of access.

Finally, the Hillcrest representative believes that the state system for PKU testing can be significantly improved. As it stands, the PKU test must be performed after forty-eight hours for a valid reading.<sup>145</sup> However, the state mandates a PKU test taken before the mother and newborn leave the hospital.<sup>146</sup> Thus, if a mother chooses to leave the hospital prior to forty-eight hours, then the hospital conducts the invalid test. Likewise, the hospital staff

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<sup>135</sup>MetroHealth II, *supra* note 76.

<sup>136</sup>*Id.*

<sup>137</sup>Clinic II, *supra* note 76.

<sup>138</sup>*Id.*

<sup>139</sup>*Id.*

<sup>140</sup>Hillcrest II, *supra* note 76.

<sup>141</sup>*Id.*

<sup>142</sup>*Id.*

<sup>143</sup>*Id.*

<sup>144</sup>Hillcrest II, *supra* note 76.

<sup>145</sup>*Id.*

<sup>146</sup>*Id.*

dislikes taking the PKU at the newborn's exit.<sup>147</sup> Thus, even if the pair stay forty-eight hours, the PKU can still fail for timeliness. The State of Ohio pays for the test but then charges the hospital for the test.<sup>148</sup> Thus, regardless of validity, the hospital must perform a PKU prior to the newborn's discharge.<sup>149</sup> The hospital may seek state reimbursement for additional PKU tests if the first test results in positive PKU.<sup>150</sup> However, the hospital still absorbs unnecessary expenses.

MetroHealth hopes for education along with research and development of maternity health care services.<sup>151</sup> MetroHealth's representative calls for interest groups to study the "where and when" the woman learns information about pregnancy, birth, and newborns.<sup>152</sup> Also, the medical groups or researchers ought to track the statistics of which created the legislation.<sup>153</sup> First, the readmission rates: does forty-eight hours of hospital care lower the newborn readmission rate?<sup>154</sup> Second, the home care: should maternity health care providers advocate for an increase in home care?<sup>155</sup> Finally, interest groups ought to track the legislation's successes and failures.<sup>156</sup> Is the legislation improving care? What does the consumer want? Also, does the payor really cover the home visits?<sup>157</sup>

### III. NATIONAL LEGISLATION—THE FEDERAL ROLE IN HEALTH CARE

Arguably, Congress may regulate payor maternity coverage contracts under its commerce power. State law does not regulate all payors. Many payors organize under one state law but operate amongst several states. Likewise, the Employees Retirement Income Security Act, (ERISA) a federal law which preempts state law, protects certain employers who act as payors.<sup>158</sup> Thus, out-of-state employers, out-of-state payors, and self-insured employers fall outside of state legislation.

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<sup>147</sup>*Id.*

<sup>148</sup>Hillcrest II, *supra* note 76.

<sup>149</sup>*Id.*

<sup>150</sup>*Id.*

<sup>151</sup>MetroHealth II, *supra* note 76.

<sup>152</sup>*Id.*

<sup>153</sup>*Id.*

<sup>154</sup>*Id.*

<sup>155</sup>MetroHealth II, *supra* note 76.

<sup>156</sup>*Id.*

<sup>157</sup>*Id.*

<sup>158</sup>GAO Study Stresses Quality Care Over Length of Postpartum Stays, BNA HEALTH CARE DAILY, Sept. 23, 1996; Janice Somerville, States Chip Away At HMOs With Regulations, Limits, 39 (16) AM. MED. NEWS 10 (1996).

However, permissible legislation does not always beget appropriate legislation. The Newborns' Act regulates payors but also affects maternity health care. Traditionally, the local concern of health and all legislation affecting health belonged to state government. The twenty-four hour payor policy motivated certain state government to lobby for the additional federal legislation. However, prior to the Newborns' Act, certain states declined to pass similar law.<sup>159</sup> Under the Newborns' Act, payors in states without a maternity law must provide coverage.<sup>160</sup> Thus, the federal government usurped certain state decisions against regulating payors which exemplifies an unbalanced federalism.

At the U.S. Constitution's ratification, states surrendered specific authority to the federal government.<sup>161</sup> Also, under the Constitution, the federal government via Congress held a new power not previously exercised by the states, that being the power to regulate commerce among the several states.<sup>162</sup> The Commerce Clause empowered the federal government to control individual state conduct which impedes or hinders the movement of commerce between the states.<sup>163</sup> Thus, Congress polices the states in the trading of things and the means to trade things between the several states.<sup>164</sup>

The Constitution and subsequent amendments balances the competing interests of the several states and the federal government, and individuals.<sup>165</sup>

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<sup>159</sup>Louise Kertesz, *Managed Care; HMOs Baling Horror Stories, Lawmakers*, MOD. HEALTHCARE, Apr. 8, 1996; David R. Olmos, *Bill To Extend HMOs' Birth Care Is Shelved Health*, L.A. TIMES, Aug. 8, 1996, A3 (California opted to not legislate maternity coverage).

<sup>160</sup>6 U.S.C. § 603.

<sup>161</sup>FEDERALIST PAPERS NO. 39. at 243 (James Madison) (Clinton Rossiter ed., 1961) [hereinafter *FEDERALIST PAPERS*]. At first, New York strongly opposed the Constitution. *Id.* at viii. Federalists, advocates of the Constitution, successfully lobbied New York to ratify the Constitution. *Id.*

<sup>162</sup>U.S. CONST. art. I, § 8, cl. 3. (Commerce Clause) "The regulation of commerce, it is true, is a new power; but that seems to be an addition which few oppose and from which no apprehensions are entertained." *FEDERALIST PAPERS*, *supra* note 161, No. 45, at 293. (James Madison).

<sup>163</sup>The interfering and unneighborly regulations of some States, contrary to the true spirit of the Union, have, in different instances, given just cause of umbrage and complaint to others, and it is to be feared that examples of this nature, if not restrained by a national control, would be multiplied and extended till they became not less serious sources of animosity and discord than injurious impediments to the intercourse between the different parts of the Confederacy.

*FEDERALIST PAPERS*, *supra* note 161, No. 22, at 144, 145 (Alexander Hamilton).

<sup>164</sup>*Id.*

<sup>165</sup>The Bill of Rights composes the first ten constitutional amendments. The freedom of speech, (U.S. CONST. amend. I) the right against unlawful search and seizure. (U.S. CONST. amend. IV) and the right to a trial by jury (U.S. CONST. amend. VI) represent a few individual rights protected under the first ten amendments.

For example, under the Tenth Amendment, state governments enjoy reserved power not delegated to the federal government nor prohibited by the Constitution.<sup>166</sup> Likewise, the Tenth Amendment also provides individuals with the reserved power not delegated to the federal government nor prohibited by the Constitution.<sup>167</sup> Thus, all constitutional power not delegated to Congress remains with the states or individuals.

The Tenth Amendment completes governmental power and effectuates dual federalism between the federal and state governments.<sup>168</sup> However, over time the balance of federalism became uncertain.<sup>169</sup> In theory, all power had been delegated to its appropriate sovereignty. However, the demarcation lines inevitably shifted, overlapped, or expanded so that the federal and state governments had difficulty defining their control.<sup>170</sup>

The federal government legislates under the enumerated powers of the United States Constitution.<sup>171</sup> The state governments legislate under their general police power affecting public safety, health, morals, and prosperity.<sup>172</sup> Just as the two levels of government differ in their power to legislate, they also differ in their motivation to legislate. The federal government, concerned with broad national issues, must approach such issues permissibly, i.e., via the commerce, taxing, or spending powers. The states, however, are concerned with narrow local issues and have broad powers to affect such issues. Thus, two levels of government, each with a power to regulate, legislate on issues that fall within its concern, either national or local. Some issues fall nicely into 'the national concern' or 'the local concern.' However, many issues become national and local concerns which may result in the two levels of government differing on the appropriate legislation. After all, the federal and state

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<sup>166</sup>U.S. CONST. amend. X. "The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people." *Id.*

<sup>167</sup>*Id.*

<sup>168</sup>FEDERALISM: THE LEGACY OF GEORGE MASON 109-117 (Martin B. Cohen ed., 1988) [hereinafter LEGACY OF GEORGE MASON]. All power not granted to the federal government belongs to the states or to the people; therefore, all power is delegated. Upon enacting the Tenth Amendment, no power known to government remained unclaimed. See generally FEDERALIST PAPERS, *supra* 161; see also U.S. CONST. amend. X.

<sup>169</sup>LEGACY OF GEORGE MASON, *supra* note 168 at 109-117.

<sup>170</sup>Dual federalism existed so long as the competing interests of federal and state governments remained somewhat balanced. *Id.* Once the balance of legislative control shifted so far into one area of government, federalism no longer remained dual or balanced. *Id.* Dual federalism originally ensured national issues to the federal government and local issues to the state governments. *Id.*

<sup>171</sup>U.S. CONST. art. I, § 81.

<sup>172</sup>BLACKS' LAW DICTIONARY 1156 (6th ed. 1990). Police power: The power of the State to place restraint on the personal freedom and property rights of persons for the protection of the public safety, health, and morals or the promotion of the public convenience and general prosperity. *Id.*

governments have competing interests: federal government for the national concern; and state government for the local concern. Such competing interests create a forum for dual federalism.<sup>173</sup>

The U.S. Supreme Court defined the perimeters of the commerce power in the 1824 *Gibbons v. Ogden*<sup>174</sup> case holding that the Commerce Clause power reached as far as interstate commerce extended.<sup>175</sup> Thus, modern day courts may use *Gibbons v. Ogden* to define the Commerce Clause broadly. In *Gibbons v. Ogden*, Congress' delegated power, the Commerce Clause and the Necessary and Proper Clause (used to effectuate a delegated power) enabled Congress to reach local activity provided the activity held an interstate element.<sup>176</sup>

Then in 1895, the Court in *United States v. E. C. Knight Company*,<sup>177</sup> acknowledged dual federalism and upheld state legislation over federal legislation by qualitatively distinguishing between manufacture and commerce.<sup>178</sup> The majority determined manufacture to be pre-commerce, thus local activity, and unreachable by Congress through the commerce power.<sup>179</sup> The *E. C. Knight* Court recognized the Tenth Amendment as an extrinsic block on the necessary and proper power.<sup>180</sup>

From 1895 to present, the Court struggles to defined commerce and to determine which government ought to legislate according to the area of regulation. Historically, when the commerce power reached extreme heights in its utilization for effectuating law, federalism reached extreme lows in its failure to balance the scales between federal and state governmental authority.<sup>181</sup> Robert B. Hawkins, cites four eras of federalism in U.S. history.<sup>182</sup>

The first, known as Dual Federalism, maintained a separation between state and national functions, by-and-large, for the nation's first 140 years under the Constitution. Then, beginning with the Great Depression, the national government began to expand its domestic functions in cooperation with the states and localities. This second era, called Cooperative Federalism, lasted until the mid-1960's when a tremendous explosion of federal grant programs and federal regulations began to dominate many state and local functions, often

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<sup>173</sup>LEGACY OF GEORGE MASON, *supra* note 168, at 111-117.

<sup>174</sup>9 Wheat. (22 U.S.) 1 (1824).

<sup>175</sup>*Id.* at 194.

<sup>176</sup>*Id.* at 195.

<sup>177</sup>156 U.S. 1 (1895)

<sup>178</sup>*Id.* at 13-14.

<sup>179</sup>*Id.* at 12.

<sup>180</sup>*Id.*

<sup>181</sup>LEGACY OF GEORGE MASON, *supra* note 168, at 109-117.

<sup>182</sup>*Id.* at 109.



setting off controversial and stressful relationships rather than cooperative ones. This third era, called Overloaded Federalism, lasted until 1981 when President Reagan introduced his New Federalism as a means of reversing federal dominance.<sup>183</sup>

Thus, federalism's balance has changed along with the increase of federal involvement in areas of local concern.<sup>184</sup>

Historically, federalism encompassed constitutional delegation of power, judicial review, and influenced society and all aspects of political life.<sup>185</sup> When balanced, the federal and the state governments struggle to create a superior political life based upon competing interests.<sup>186</sup> When biased to the national government, states lose their voice and power in defending local interests. Likewise, when biased to the state interest, the nation suffers because local interest superseded national concern.<sup>187</sup>

Events in U.S. history such as the Civil War,<sup>188</sup> the Great Depression,<sup>189</sup> and the Civil Rights Movement<sup>190</sup> drove the federal government to legislate in areas

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<sup>183</sup>*Id.*

<sup>184</sup>In 1995, the Court decided two cases affecting the Commerce Clause and federalism. First, in April, the Court held in *United States v. Lopez*, 115 S. Ct. 1624 (1995), that Congress exceeded its Commerce Clause power by criminalizing gun possession within a school zone. *Id.* The *Lopez* Court held that it shall not infer interstate activity when the activity (local student with a gun at a local school) is obviously local. *Id.* at 1634.

Second, in May, the Court held in *United States Term Limits, Inc. v. Thornton*, 115 S. Ct. 1842 (1995), that a state exceeded its sovereign power when it established additional qualifications for state congressional elections. *Id.* The dissenters, Justices Thomas, Rehnquist, O'Connor, and Scalia, favored the Tenth Amendment as a real power for the people and argued for a completed power. *Id.* at 1876-1877. The *Lopez* majority and the *Thornton* dissent constitute ideal federalism and the closest attempt to regain some sense of balance between federal and state regulation.

<sup>185</sup>FEDERALIST PAPERS, *supra* note 161, NO. 46, at 296-297 (James Madison).

<sup>186</sup>*Id.*

<sup>187</sup>*Id.*

<sup>188</sup>FEDERALISM: THE SHIFTING BALANCE 4-6 (Janice C. Griffith ed., 1989) [hereinafter THE SHIFTING BALANCE].

[An] . . . important development was that the Civil War established the principle that the federal government could sanction the states if they did not come into line. The recognition that this was true was profound and is traumatic. The Civil War changed irreversibly the whole psychological sense of the federal government's role in the United States. From that point forward it was clear who was in the driver's seat.

REGULATION, FEDERALISM, AND INTERSTATE COMMERCE 151 (A. Dan Tarlock ed. 1981) (statement by Edmund W. Kitch).

<sup>189</sup>Arguably, the judiciary conceded to President Roosevelt's pressure and permitted President Roosevelt's New Deal Plan which nationalized local concerns. THE SHIFTING BALANCE, *supra* note 188, at 7-8.

of local concern regardless of the constitutional delegation of powers and notions of federalism. Arguably, the current unbalanced federalism is a logical extension of the social reform which the U.S. desperately needed after the Civil War.<sup>191</sup>

The Newborns' Act coincides with the seventy-fifth year since the federal government first legislated in the local concern of maternity health care.<sup>192</sup> The Maternity Act of 1921<sup>193</sup> represents the first federal regulation, which although permissible under the spending power, invaded state sovereignty by regulating maternity health care.<sup>194</sup> The federal government, via the Maternity Act, established one of the first grant-in-aid inducement programs. At the time, maternal and infant mortality levels increased throughout the nation.<sup>195</sup> Thus, Congress established a federal board that set guidelines, appropriated funds, and policed state compliance of the federal guidelines.<sup>196</sup> The federal

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<sup>190</sup>WILLIAM H. CHAFE, *THE UNFINISHED JOURNEY* 235 (1986).

[President] Johnson presided over the most extraordinary display of legislative action the country had ever seen - the achievements of the 1965-66 Congress outpacing even the dazzling array of programs enacted during the first two years of the New Deal. The 89th Congress began by enacting long-stalled legislation such as federal aid to education and Medicare. But then it moved beyond, into new areas, passing an act for higher education, a housing act that included rent subsidies, a demonstration cities program, aid to urban mass transit, Operation Headstart, manpower training, a teachers' co-op, new provisions for mental health facilities, environmental safety legislation, truth in packaging, rent supplements, and high-speed mass transit.... Johnson even secured congressional approval for the Voting Rights Act of 1965.

*Id.*

<sup>191</sup>REGULATION, FEDERALISM, AND INTERSTATE COMMERCE, *supra* note 188, at 151.

<sup>192</sup>The Maternity Act, ch. 135, 42 Stat. 224 (1921). The appropriations ended in 1929 by Act of Jan. 22, 1927, ch. 53, 44 Stat. 1024 (1927).

<sup>193</sup>The Maternity Act, ch. 135, 42 Stat. 224 (1921).

<sup>194</sup>The Act established a medical board to determine appropriate means to provide for a medically acceptable level of hygiene for mothers and newborns.

<sup>195</sup>Roy L. Brooks & Sharon A. Cheever, *The Federal Loan Guarantee Program: A Unified Approach*, 10 J. CORP. L. 185 (1984)

[C]itizens and private industry became recipients of federal financial assistance in greater numbers near the turn of the century. These new programs had the potential to subject the federal coffers to greater drain and brought unwavering governmental support to private industry, seemingly in conflict with the hands-off, laissez-faire attitude of the nineteenth century. Yet many of these new programs of assistance were reasonable responses to the socio-economic conditions of a changing society.... To deal with the increasing rate of infant mortality during the early decades of this century, Congress passed The Maternity Act of 1921.

*Id.* at 197.

<sup>196</sup>David E. Engdahl, *The Spending Power*, 44 DUKE L. J. 1, 35 (1994).

guidelines determined minimum standards of maternity ward hygiene for the states to enforce. The appropriations lasted for approximately eight years,<sup>197</sup> but the incentive theory of federal control continues to generate federal regulation in areas of local concern.

The Maternity Act did not pass unnoticed by the invaded state governments. The state in *Commonwealth of Massachusetts v. Mellon*,<sup>198</sup> argued that its

rights and powers as a sovereign state and the rights of its citizens [had] . . . been invaded and usurped by the [ ] expenditures and acts, and that, although the state [had] . . . not accepted the act, its constitutional rights [were] . . . infringed by the passage thereof and the imposition upon the state of an illegal and unconstitutional option either to yield to the federal government a part of its reserved rights or lose the share which it would otherwise be entitled to receive of the moneys appropriated.<sup>199</sup>

The *Mellon* Court held that Massachusetts' arguments were political and nonjusticiable which removed the case from the Court's original jurisdiction.<sup>200</sup> Massachusetts believed that Congress ought not legislate in an area reserved to state sovereignty. However, the Court held that consensual surrender of state sovereignty permitted congressional action in areas not originally surrendered to the federal government.<sup>201</sup>

Arguably, the *Mellon* Court abandoned traditional notions of dual federalism. However, the *Mellon* Court grounded its holding on known history up to 1921 which showed infant and maternal mortality rates needing intervention. In 1921, the nation, unconcerned with usurping state power, demanded appropriate and uniform hygiene for mothers and newborns. Unfortunately, strict notions of federalism changed along with the *Mellon* holding.<sup>202</sup> Fortunately, the federal government established minimum standards of hygiene for mothers and newborns which prompted concern and intervention for maternity health care.

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<sup>197</sup>The Maternity Act, ch. 135, 42 Stat. 224 (1921).

<sup>198</sup>262 U.S. 447 (1923).

<sup>199</sup>*Id.* at 479-480.

<sup>200</sup>*Id.* at 480 ("We have reached the conclusion that the case[] must be disposed of for want of jurisdiction without considering the merits of the constitutional questions.").

<sup>201</sup>262 U.S. at 482 ("[Massachusetts] alleged that the statute constitutes an attempt to legislate outside the powers granted to Congress by the Constitution and within the field of local powers exclusively reserved to the states.").

<sup>202</sup>The *Mellon* Court had no idea that the federal government would expand its use of the grant-in-aid inducement programs to direct state agendas such as drinking age, *South Dakota v. Dole*, 483 U.S. 203 (1987), and waste management, *New York v. United States*, 505 U.S. 144 (1992).

## IV. HOW THE REGULATIONS MAY AFFECT MATERNITY HEALTH CARE

The combined state and federal regulations intentionally restrict payor contracts. However, the legislations may restrict maternity health care as well. Critics of the legislation argue that the legislation: standardizes maternity health care;<sup>203</sup> increases insurance costs which, under a trickle-down effect, harms certain consumer coverage;<sup>204</sup> and falls short of an appropriate length of stay.<sup>205</sup> Likewise, the federal government perpetuates unbalanced federalism by legislating in the local concern of health against some state judgments.<sup>206</sup> Granted, the state and the federal governments legislate permissibly. However, permissible legislation does not always beget appropriate legislation. The Newborns' Act is constitutionally valid in terms of the power to enact but it reflects an incorrect view of federalism. The Maternity Law, appropriate legislation, benefits consumers and redistributes professional autonomy to physicians. However, the better solution could have been for medical groups to independently bargain with payors for more autonomy in maternity health care services.

The Maternity Law asserts that it does not standardize maternity health care services.<sup>207</sup> The Newborns' Act fails to contain similar language. However, critics of the legislation predict that the law will standardize forty-eight hours of post delivery hospital care.<sup>208</sup> Several problems result from legislated standards of health care.

Hospitalization ought to be utilized because of need. Consumers from the 1970's successfully de-medicalized childbirth. In fact, current medical groups and consumers assert that birth is a wellness event.<sup>209</sup> Also, professionals and legislators admit that birth and postpartum hospital care compose mere parts to the continuum of maternity health care.<sup>210</sup> To focus on and standardize one element of the continuum detracts from the entire process. The law may entice consumers to accept the extended hospital time. However, the consumer may not need the additional hospital time. In fact, certain consumers may benefit from less hospital time with a home visit. The maternity legislation permits such a scenario. However, if the extended hospital stay becomes standardized, then uninformed consumers will miss their options. Currently, the likelihood

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<sup>203</sup>DeGiralomo, *supra* note 42; GAO Study, *supra* note 158.

<sup>204</sup>Somerville, *supra* note 158.

<sup>205</sup>GAO Study, *supra* note 158; see also Paula A. Braveman, *Short Hospital Stays For Mothers and Newborns*, 42 (5) J. FAM. PRAC. 523 (1996).

<sup>206</sup>Kertesz, *supra* note 159; Olmos, *supra* note 159.

<sup>207</sup>1996 Ohio Laws 199.

<sup>208</sup>See *Physicians Blame Insurance*, *supra* note 6.

<sup>209</sup>Clinic II, *supra* note 76.

<sup>210</sup>Newborn's Act 6 U.S.C. § 606; Hillcrest II, *supra* note 76; DeGiralomo, *supra* note 42.

of extended stay standardization depends in large part on physicians and hospitals and their perception of the laws.

Likewise, consumers may be "lull[ed] . . . into a false sense of security."<sup>211</sup> Consider that the payors defended their twenty-four hour standards with statistics that failed to contradict the policy.<sup>212</sup> Advocates for the legislation successfully attacked the payor data.<sup>213</sup> However, the lobbyists for the legislation did not offer conclusive data supporting a forty-eight hour hospital stay.<sup>214</sup> In fact, certain reports criticize the laws for ignoring the third postpartum day when potential illness or infection tends to surface in the mother and the newborn.<sup>215</sup> Consumers who satisfy themselves with forty-eight hours for hospital care may ignore the potentially dangerous period for the mother and the newborn.<sup>216</sup>

Also, hospitalization ought to be utilized by need because of its expense. However, consumers and physicians may expect and demand the forty-eight hour coverage regardless of the mother and newborn need for such service.

By mandating coverage of maternity days that are not medically necessary, [the legislation] . . . would increase health care costs and cause employers to cut back or eliminate other types of coverage, according to . . . [one critic]. The measure may lead to increased litigation and higher malpractice costs by placing doctors, nurse midwives, and other providers at a higher risk of malpractice suits when a patient is released from the hospital sooner than 48 hours.<sup>217</sup>

Above all, critics of the legislation call for medically necessary maternity health care.<sup>218</sup> Allowing patients additional but unnecessary hospital care burdens the health care system. Consider the cost in space, staffing, and increased premiums. Likewise, permitting patients a specified amount of hospital care that may be insufficient for the patient also burdens the health care system in preventable illness, readmission, and dissatisfied consumers. In contrast, permitting appropriate and medically necessary hospital care likely advances the health care system. Consider that lobbyists for the legislation did not offer evidence of appropriate research supporting forty-eight hour hospital

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<sup>211</sup>GAO Study, *supra* note 158.

<sup>212</sup>Groups Oppose Maternity Care Bill Mandating Length-Of-Stay Benefits, BNA HEALTH CARE DAILY, Sept. 4, 1996 [hereinafter *Groups Oppose*].

<sup>213</sup>Hearings on § 969, *supra* note 5, 81, 82 (Augusto Sola, M.D.).

<sup>214</sup>Groups Oppose, *supra* note 212.

<sup>215</sup>GAO Study, *supra* note 158; Braveman, *supra* note 205.

<sup>216</sup>Braveman, *supra* note 205.

<sup>217</sup>Groups Oppose, *supra* note 212 (quoting letter by the Coalition for Optimal Maternity Care).

<sup>218</sup>*Id.*; GAO Study, *supra* note 158.

stays. Yet, the Newborns' Act mandates forty-eight hour coverage.<sup>219</sup> Arguably, the forty-eight hour regulation may prove to be as arbitrary as the twenty-four hour coverage.<sup>220</sup>

One author calls for family physicians to take an active role in early postpartum home care.<sup>221</sup> Consider the U.S. health care system and society's infatuation with specialized medicine.

Third party payers . . . should not be viewed as the only obstacle to a more rational and humane policy on early postpartum care. Another contributing factor is the specialty-oriented fragmentation of care among different providers without anyone taking overall responsibility for the care of both mother and baby. In addition, most physicians have viewed home-based care as the province of nurses, and may be less than enthusiastic about incorporating postpartum nurse home visiting into their routine practice if they see it as threat to their role or income.<sup>222</sup>

Thus solutions for the inappropriate health care problem, i.e. early discharge, may require more than legislative intervention. Perhaps a large portion of the movement towards appropriate health care lies within the medical profession's control.

Additionally, medical and payor groups will unlikely absorb additional costs resulting from medically unnecessary or inappropriate health care services. For example, several New Jersey payors discovered a way, via coverage per-birth, to pass additional costs onto the hospital.<sup>223</sup> Likewise, Hillcrest had to shift costs to the payor once maternity legislation permitted mothers to opt for a home visit with less than forty-eight hours of hospital care post birth.<sup>224</sup> Consider also that maternity wards generate revenue for hospitals.<sup>225</sup> The maternity legislation fails to address the economic incentive of medical and payor groups and fails to protect consumers. Consumers will likely absorb the additional maternity health care cost through increased

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<sup>219</sup>6 U.S.C. § 601, et al. (1996).

<sup>220</sup>Braveman, *supra* note 205.

<sup>221</sup>*Id.* (interpreting "early discharge" as that which occurs prior to seventy-two hours.).

<sup>222</sup>*Id.*

Family physicians have a unique contribution to make in speaking to the issues surrounding early postpartum care because of their relationships not only with mothers and babies but with families as well . . . . Family physicians should provide leadership in the development of health services that meet the needs of mothers and newborn babies and should serve as outspoken advocates on their behalf.

*Id.*

<sup>223</sup>1994 N.J. Laws 117.

<sup>224</sup>Hillcrest II, *supra* note 76.

<sup>225</sup>Clinic I, *supra* note 76; Hillcrest I, *supra* note 76; MetroHealth I, *supra* note 76.

premiums or by employer cancellation of health care coverage.<sup>226</sup> Currently, forty million Americans live without health care coverage of which the majority are women or children dependents of employed families.<sup>227</sup> The uninsured population is composed of working class families whose employers do not offer health care insurance.<sup>228</sup> Thus, most uninsured citizens fail to qualify for public assistance. Critics charge that the maternity legislation will cause employers to drop health care coverage.<sup>229</sup> Arguably, the uninsured class will significantly increase if employers refuse to absorb the additional costs of health care coverage. Currently, MetroHealth concedes to the possibility of additional uninsured mothers and newborns and prepares for innovative services to lighten the financial blow to uninsured families.<sup>230</sup>

Arguably, the Newborns' Act impedes market negotiations between payors, consumers, and physicians. Consider negotiations between the Arizona Medical Association and several payors within Arizona.<sup>231</sup> Prior to the Newborns' Act, the two groups reached agreements that ensured physician autonomy in directing postpartum care.<sup>232</sup> The Arizona legislature deferred to the medical and payor groups by abandoning a proposed maternity law.<sup>233</sup> The Newborns' Act undercut those negotiations by mandating forty-eight hour coverage in Arizona and other states without maternity laws.

Thus, issues of federalism surface and beg the question of who appropriately legislates health care? States, such as Ohio, who desired strong maternity legislation accepted federal activity in local health care legislation to impede payors who fell outside of state regulations. However, states such as Arizona abandoned maternity legislation for a more market-oriented approach to solving health care problems. Unfortunately, society has not determined the better state's approach to health care because the Newborns' Act undercut developments in those states that abandoned maternity legislation. Perhaps the federal government ought to have allowed states like Arizona to develop their non-legislative approach to health care dilemmas prior to enacting the Newborns' Act.

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<sup>226</sup>*Groups Oppose*, *supra* note 212.

<sup>227</sup>Interview with Mark Chassim, Director of New York Health Care, in New York (1994) (on file with Dr. Samuel Gorovitz, Syracuse, N.Y.) (40 million Americans have no health insurance).

<sup>228</sup>*Id.*

<sup>229</sup>*Groups Oppose*, *supra* note 212.

<sup>230</sup>*MetroHealth II*, *supra* note 76.

<sup>231</sup>*Kertesz*, *supra* note 159.

<sup>232</sup>*Id.*

<sup>233</sup>*Id.*

#### V. CONCLUSION

Thus, maternity legislation seemingly advances maternity services yet in reality may impede and burden maternity health care. Mandating health care coverage may indirectly standardize health care services. Standardized services may result in unnecessary or inappropriate hospital care. The misuse of hospital care burdens the consumers in service and cost. Thus, consumers will likely pay the cost for unnecessary or inappropriate maternity legislation.

Of the legislatures, the states better legislate maternity health care. State legislators are vested with the power to legislate in health via the Tenth Amendment. Likewise, states remain localized to the needs of their citizens' local concerns. For example, certain states actively pursued maternity legislation while other states allowed the opposing groups to negotiate better health care services absent legislative intervention. What may have been a fine non-legislative approach to health care will not develop because the federal intervention supersedes the negotiations. Arguably, the states deserve a chance to develop non-legislative means to deal with a local issue absent federal intervention. Federalism demands that the states be free to exercise local state concern consistent with the Constitution.

Finally, the maternity legislation appeases many consumers and medical groups. However, the victory may seem worthless if payors discontinue maternity coverage. Consumers, once denied appropriate coverage, may find themselves without health care coverage. Realistically, society cannot afford to think that only the payors will absorb the costs produced by maternity legislation.

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